

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 2 5

2. STATE:

Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

11/05/01

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.272

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ 14.4 millionb. FFY 2003 \$ 14.4 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Page 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

None

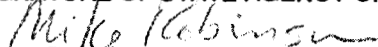
10. SUBJECT OF AMENDMENT:

Payments for Inpatient Hospital Services

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:Review delegated to the Commissioner
Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Mike Robinson

14. TITLE:

Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Mike Robinson, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

December 13, 2001

18. DATE APPROVED:

March 7, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

November 5, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

(19) Supplemental Payments for Private Hospitals

Private hospitals (non-government owned or operated) qualify to receive supplemental payments from a pool in an amount to be determined annually by the Department. The Department will establish a pool in an amount equal to (a) one-half of the payments made to participating facilities under (18) of Attachment 4.19-A, page 14, and section F of Attachment 4.19-B, page 20.12(g) after (b) deducting the non-federal share of the payments, less the funds necessary to reimburse the participating facilities' Medicaid "shortfall", [defined as the difference between their aggregate payments for all inpatient hospital services (exclusive of disproportionate share payments) and their aggregate allowable costs of providing inpatient hospital services]. This amount shall be matched with federal financial participation to establish the total fund.

The supplemental payments shall be made quarterly and distributed proportionately among qualifying hospitals to the extent of their Medicaid costs as compared to the total Medicaid costs of all qualifying hospitals, not to exceed its "shortfall". The pool will be distributed pro rata, so that each qualifying hospital will receive a percentage of the pool equal to its pro rata share of the aggregate Medicaid costs of all qualifying hospitals.

The "shortfall" will be calculated on a per diem or per discharge basis, using the most recent cost reports used to establish hospital rates, and applied to claims data from the MMIS for the most recently completed fiscal year. Revenues or costs associated with days of care provided under managed care arrangements shall not be considered in determining the shortfall.